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	N046086	A. BUILDING: _____ B. WING _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations 101217, 97025, 91836, 91565 at the above named assisted living facility conducted on 7-5-16, 7-6-16, 7-7-16, 7-11-16, 7-12-16 and 7-13-16.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (B) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for 1 (#707) of 2 closed record review residents, the administrator failed to ensure the resident was not subjected to neglect when facility staff failed to respond to the resident ' s call light in a timely fashion and the facility failed to have the call light system checked to ensure it was working properly. Findings included: - Record review for resident #707 revealed admission on 4-30-13 with diagnoses Adult	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Failure to Thrive, Hypertension, Hypothyroidism, Depression, Congestive Heart Failure, Atrial Fibrillation, Cerebrovascular Accident and Edema.

The Functional Capacity Screen (FCS) dated 10-12-15 recorded resident required physical assistance with dressing; supervision with bathing and management of medications and treatments. Continent of bladder. Uses walker.

The Negotiated Service Agreement/Health Care Service Plan dated 10-1-15 recorded the following services:
Bathing: Full assistance with all aspects of bathing.
Dressing: Reminders to dress and assistance with clothing selection and completion of task.
Ambulation/Transfer: independent with ambulation and transfers with walker. Staff to check on resident every two hours for safety.

Nurses notes, Facility incident reports and call light records documented the following:

2-4-16 resident #707 fell in the bathroom at approximately 7:40 a.m. and activated his/her call pendant. The call light record documented staff responded to call at 9:10 a.m. - a response time of 89 minutes.

2-8-16 Resident #707 was found on the floor by family at approximately 9:45 p.m.; resident stated he/she had pushed his/her call pendant with no response.

2-10-16 Resident #707 found on the floor. Call light records documents pendant activated at 7:48 a.m. and staff responded at 8:54 a.m. - response time of 64 minutes with record showing

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the pendant was activated 25 times.
All incident reports lacked documentation of investigations including staff statements and inspection of call pendant to determine if working properly.

Interview on 7-7-16 with administrative staff B stated there were 3 certified staff working on assisted living on 2-4-16. All staff admitted they heard the call light for resident #707 going off and didn ' t respond. Confirmed the certified staff were written up but denied getting written statements from staff regarding where they were and what they were doing that prevented answering the resident ' s call light. Stated he/she thought the resident was not pushing the button hard enough. He/She checked the resident ' s call light and found it to be working that day, but confirmed this was not documented and he/she did not have maintenance check the call light system or confirm resident ' s ability to consistently push the call button in all the way.

Interview on 7-12-16 at 3:31 pm with certified staff J confirmed he/she was working 2-10-16 and was giving a shower when resident ' s call light went off so was unable to answer the light. Stated the call light did not ring to his/her pager, it rang to the other two staff ' s pagers. Stated certified staff N answered the resident ' s light.

Interview on 7-12-16 at 3:35 with certified staff N confirmed he/she answered resident #707 ' s call light on 2-10-16. Stated he/she answered the light as soon as it showed on his/her pager, went to the resident ' s room and found the resident on the floor. Stated he/she didn ' t feel the pagers were working properly and was not aware the light had been going off for over an hour. Stated when the call light first showed up on his/her

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pager it showed as a " repeat " , it usually goes to " repeat " after 4 minutes.

Confidential Interview on 7-12-16 stated the call pendants are worn around the neck and demonstrated that when pushed properly, a small light flashes red briefly and the pager registers that the particular pendant has been pushed according to room number. Therefore, if a resident is looking at the pager, they can tell if it has been pushed. Stated if the pager goes off for longer than 4 -5 minutes, it will show as a " repeat " push and continue to go off on the pager until a staff member goes to the pager and pushes a small button to shut it off. Further stated most staff don ' t think the pager/pendants are working properly because they don ' t always receive the notification on the pager and sometimes don ' t have enough working pagers to go around. Some residents have moved in and had no call pendant immediately available to them. Stated he/she could not remember batteries ever being checked on the pendants.

Review of facility maintenance records revealed call pendants checked on 4-22-15, 12-17-15, and 3-25-16. Call pendant for resident ' s apartment was last checked 12-17-15. The call light was not checked again during the routine check on 3-25-16.

Interview with maintenance staff M on 7-7-16 at 11:15 am stated he/she checks the call light system " twice a year " and confirmed he/she was not requested to check whether the call light was working properly for resident #707 in February.

For resident #707 the administrator failed to ensure the resident was not subjected to neglect

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S3026	Continued From page 4 when facility staff failed to respond to the resident ' s call light in a timely fashion and the facility failed to have the call light system checked to ensure it was working properly.	S3026		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(b) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for 4 (#701, #702, #704 and #705) of 6 sampled residents, the administrator failed to ensure a licensed nurse shall assess any resident whose functional capacity screening indicated the need for health care services. Findings included:	S3080		

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S3080	Continued From page 5 - Record review for resident #701 revealed admission on 6-4-16 with diagnoses Congestive Heart Failure, Coronary Artery Disease, Peripheral Vascular Disease, Atrial Fibrillation, Diabetes Mellitus Type 2, Hyperlipidemia, Renal Insufficiency and History of Myocardial Infarction. The Functional Capacity Screen (FCS) dated 5-26-16 recorded resident independent with activities of daily living. Current problem/risks identified included impaired hearing and impaired vision. The FCS was signed by administrative staff A. The FCS lacked documentation of assessment by a licensed nurse. The FCS was updated on 7-6-16 and recorded resident #701 required supervision of transfers and walking/mobility and required physical assistance with dressing. This FCS was signed by administrative staff A. The FCS lacked documentation of assessment by a licensed nurse. Interview on 7-5-16 at 4:35 pm with administrative staff A confirmed both FCSs lacked documentation of assessment by a licensed nurse. Stated resident required health care services: physical assistance with dressing, stand by assistance with transfers and walking/mobility (uses a walker). Confirmed the FCS dated 5-26-16 was not accurate and not in accordance with the negotiated service agreement. - Record review for resident #702 revealed admission on 1-23-15 with diagnoses Cerebral Vascular Accident with Hemiparesis, Dysphagia, Hypertension, Hyperlipidemia, and Glaucoma. The Functional Capacity Screen (FCS) dated	S3080		

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S3080	Continued From page 6	S3080		

5-31-16 recorded resident unable to perform bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; independent with eating. Frequently incontinent. Cognition: problems with memory/recall. Current problems/risks identified included falls and impaired hearing. The FCS was signed by the responsible party. The FCS lacked documentation of assessment by a licensed nurse.

Interview on 7-6-16 at 2:50 pm with licensed staff D confirmed the FCS lacked documentation of assessment by a licensed nurse.

- Record review for resident #704 revealed admission on 3-2-8-13 with diagnoses Depression, Constipation, Weight Loss, Hypothyroidism, and Senile Dementia Alzheimer's Type.

The Functional Capacity Screen (FCS) dated 4-1-16 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating; unable to perform management of medications/treatments. Frequently incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Communication: sometimes understandable and sometimes understands. Current problems/risks identified included falls, socially inappropriate disruptive behavior and impaired decision-making. The FCS was signed by the responsible party and administrative staff B. The FCS lacked documentation of assessment by a licensed nurse.

Interview on 7-7-16 at 11:00 am with

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S3080	Continued From page 7 administrative staff A confirmed the FCS lacked documentation of assessment by a licensed nurse. - Record review for resident #705 revealed admission on 6-18-16 with diagnosis of Hypertension. The Functional Capacity Screen (FCS) dated 6-18-16 recorded resident independent with activities of daily living. Current problems included impaired hearing. The FCS was signed by administrative staff A. The FCS lacked documentation of assessment by a licensed nurse. Interview on 7-7-16 at 11:00 am with administrative staff A confirmed the resident was not assessed by a licensed nurse prior to admission to the facility. The administrator failed to ensure a licensed nurse performed the assessments and signed the functional capacity screens for residents #701, #702, #704 and #705.	S3080		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		

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S3155	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for 1 (#707) of 2 closed record review residents, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and were in accordance with the functional capacity screening and the negotiated service agreement when the licensed nurse failed to reassess the resident after two hospital admissions. The resident experienced three falls from 2-4-16 to 2-10-16 which resulted in extensive bruising, pain and required three trips to the emergency room. Findings included: - Record review for resident #707 revealed admission on 4-30-13 with diagnoses Adult Failure to Thrive, Hypertension, Hypothyroidism, Depression, Congestive Heart Failure, Atrial Fibrillation, Cerebrovascular Accident and Edema. The Functional Capacity Screen (FCS) dated 10-12-15 recorded resident required physical assistance with dressing; supervision with bathing and management of medications and treatments; and independent with toileting, transfers, walking/mobility and eating. Continent of bladder. No problems with cognition and communication. No current problems or risks identified. Uses walker. The FCS lacked documentation of reassessment upon hospital return on 1-15-16	S3155		

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S3155	Continued From page 9	S3155		

and lacked documentation of fall risk after fall on 2-4-16 and return from hospital on 2-8-16.

The Negotiated Service Agreement/Health Care Service Plan dated 10-1-15 recorded the following services:
Bathing: Full assistance with all aspects of bathing.
Dressing: Reminders to dress and assistance with clothing selection and completion of task.
Ambulation/Transfer: independent with ambulation and transfers with walker. Staff to check on resident every two hours for safety.
The NSA/HCSP lacked documentation of services to address resident's fall risk, and overall change in condition upon hospital return (including increased weakness, use of oxygen and daily monitoring of weight).

Review of hospital records reveal resident was admitted to hospital with diagnoses of pneumonia on 1-8-16 and discharged back to facility on 1-15-16 with instructions for daily monitoring of weight due to edema.

Documentation of physician's follow up visit dated 1-22-16 stated: "Seen for hospital follow up, recently hospitalized with pneumonia ...complaint is shortness of breath, tiredness and fatigue ...has been having to sleep in chair. Gets very short of breath when he/she lays down ...Oxygen saturation 89% at rest in wheelchair. Patient not able to stand today. Edema from knees down both lower extremities ...complaint of no appetite, shortness of breath, orthopnea and paroxysmal nocturnal dyspnea."

Review of hospital records revealed resident returned to hospital on 2-4-16 when seen by physician for exacerbation of congestive heart

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S3155	Continued From page 10	S3155		

failure. Returned to facility on 2-8-16.

Nurse's Notes stated:
2-4-16 at 9:40 am: "CNA (Certified Nurse Aide) went into resident's apartment to wake him/her for breakfast. CNA found resident sitting on bathroom floor in front of toilet. Resident stated, 'I slipped to the floor.' ...Range of motion intact. Bruise to left side of bottom, no other apparent injuries ...has a doctor appointment this afternoon.." Signed by licensed staff D.
2-4-16 at 12:00 pm: "Resident had non-injury fall. Stated he/she slipped to floor. Bruise to left side of bottom. Will continue to monitor. Physical Therapy/Occupational Therapy to evaluate and treat. Resident did have a doctor's appointment today and family member will mention fall to doctor." Signed by licensed staff Q.
2-5-16 at 10:40 am: "This nurse called resident's family member to find out how resident was doing as he/she never returned to this facility. Family member confirmed resident is at hospital, admitted 2-4-16 ... " Signed by licensed staff Q.
2-8-16 at 8:45 pm: "Resident on readmit follow up. Alert oriented but weak. Voice is very low. Takes quite a bit of effort to project. Denies any discomfort at the moment ..." Signed by licensed staff L.
2-8-16 at 10:30 pm: "Resident found on floor at about 9:45 pm by family member. This writer was alerted. Vital signs were taken. Family member very angry and said resident was on the floor for over 30 minutes and pushed his/her call button and received no help. No pages seen on pager. 911 called per family member's request. Bruise on right hip noted. Resident transported to hospital." Signed by licensed staff L.
Note: resident returned to facility same night.
2-10-16 at 9:35 am: "Resident was found on apartment floor with a bump on head and with

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S3155	Continued From page 11 pain in right arm. 911 was called and transferred to resident to hospital where family member will meet him/her..." Signed by licensed staff Q. Facility incident reports documented falls on 2-4-16 at 7:40 am, 2-8-16 at 9:45 pm and 2-10-16 at 9:00 am. All incident reports lacked documentation of investigations. Interview on 7-12-16 at 3:10 pm with licensed staff D upon review of closed record confirmed the record lacked any other FCS or NSA and the resident was not reassessed upon return from the hospital on 1-15-16 or 2-8-16. Confirmed resident was weaker when he/she returned from the hospital each time. For resident #707, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident when the licensed nurse failed to reassess the resident after two hospital admissions and implement interventions to address resident's increased weakness and fall risk. The resident experienced three falls from 2-4-16 to 2-10-16 which resulted in extensive bruising, pain and required three trips to the emergency room.	S3155		
S3167 SS=F	26-41-204 (f) Health Care Services (f) Each administrator or operator shall ensure that a licensed nurse is available to provide immediate direction to medication aides and nurse aides for residents who have unscheduled needs.	S3167		

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S3167	Continued From page 12 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(f) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for all residents and staff, the administrator failed to ensure that a licensed nurse is available to provide immediate direction to medication aides and nurse aides for residents who have unscheduled needs. Findings included: - During entrance interview on 7-7-16 at 12:45 pm with administrative staff A and administrative staff B stated licensed staff C was "always on call" for unscheduled needs and sometimes the LPNs "fill in." Review of facility "Staffing Sheets" for June 2016, revealed daily staffing assignments with an "on call" person designated at the top of each sheet. These designated staff range included certified staff J, licensed staff C, certified staff K and administrative staff A. Interview on 7-7-16 around 11:30 am with administrative staff A stated the certified staff were on call "just for staffing" if someone called in. Stated whenever licensed staff C's name was on the sheet, staff were instructed to call him/her (administrative staff A). Confirmed he/she had been taking call for all staff and resident issues including nursing issues since 6-3-16. Interview on 7-7-16 at 2:00 pm with licensed staff C stated he/she was off on medical leave. Stated	S3167		

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S3167	Continued From page 13 he/she was "always on call" from 2-4-16 until the evening of 5-8-16. Stated he/she returned to work on 5-31-16 and left again on 6-3-16. After 6-3-16 he/she has not been on call and had not received any calls from facility staff. Interview on 7-7-16 at 11:40 am with licensed staff D stated after licensed staff C went on medical leave, he/she was not given any more duties except checking physician's orders, medication administration records and tuberculosis skin testing. Stated he/she was not on call for facility staff. Confidential Interviews on 7-6-16 and 7-7-16 stated when there is no nurse scheduled, the medication aide is responsible and they have been instructed to call administrative staff A. Per interview and written statements provided on 7-7-16 by administrative staff B and licensed staff G, licensed staff G would be available for facility staff effective immediately. For all residents and staff, the administrator failed to ensure that a licensed nurse was available to provide immediate direction to medication aides and nurse aides for residents who have unscheduled needs from 6-3-16 to 7-7-16.	S3167		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care	S3200		

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S3200	Continued From page 14 provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for 3 (#702, #703, #704) of 6 sampled residents and 1 (#708) of 2 closed record review residents, the administrator failed to ensure that all medications and biologicals are administered in accordance with professional standards of practice. Findings included: - Record review for resident #702 revealed admission on 1-23-15 with diagnoses Cerebral Vascular Accident with Hemiparesis, Dysphagia, Hypertension, Hyperlipidemia, and Glaucoma. The Functional Capacity Screen (FCS) dated 5-31-16 recorded resident unable to perform management of medications/treatments. The Negotiated Service Agreement/Health Care	S3200		

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S3200	Continued From page 15 Service Plan dated 5-31-16 recorded services for staff assistance "with all aspects of medication management." Review of Medication Administration Record (MAR) for June 2016 revealed the following medications lacked documentation of administration: Tramadol 50 mg (milligrams) at 9:00 pm (pain) on 6-4-16; Trusopt 2% eye drops instill 1 drop each eye at 8:00 pm (glaucoma) on 6-4-16; Neurontin 100 mg 1 capsule at 8:00 pm (neuropathy) on 6-8-16; Doxepin 10 mg capsule (insomnia) circled as not administered on 6-5-16, 6-6-16, 6-7-16, 6-8-16, 6-9-16, 6-10-16, 6-11-16 and 6-17-16 (documented on back of MAR that medication was not available; record lacked documentation of notification of physician that medication had not been administered as ordered). Review of MAR for July 2016 revealed the following medication lacked documentation of administration: Trusopt 2% eye drops (glaucoma) instill 1 drop each eye at 8:00 pm on 7-1-16 and 7-2-16. Interview on 7-6-16 at 2:35 pm with licensed staff D confirmed the above medications lacked documentation of administration on the above dates and times and confirmed the physician not notified that resident had not received the Doxepin as ordered. Further confirmed no current system in place for monitoring the Medication Administration Records. - Record review for resident #703 revealed admission on 2-12-13 with diagnoses Parkinson's	S3200		

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S3200	Continued From page 16 Disease, Dementia, Hypertension, Hyperlipidemia, Cerebral Vascular Accident and Hypothyroidism. Review of MAR for July 2016 revealed the following medication lacked documentation of administration: Pravastatin 80 mg (cholesterol) on 7-3-16 at 8:00 pm; Calcium 600 mg (supplement) on 7-2-16 at 5:00 pm; Docusate 100 mg capsule (stool softener) on 7-1-16 and 7-2-16 at 5:00 pm; Potassium Chloride Extended Release 20 meq (milliequivalents) (supplement) on 7-2-16 at 5:00 pm. Interview on 7-7-16 at 2:35 pm with licensed staff D confirmed the above medications lacked documentation of administration on the above dates and times. - Record review for resident #704 revealed admission on 3-2-8-13 with diagnoses Depression, Constipation, Weight Loss, Hypothyroidism, and Senile Dementia Alzheimer's Type. The Functional Capacity Screen (FCS) dated 4-1-16 recorded resident unable to perform management of medications/treatments. The Negotiated Service Agreement/Health Care Service Plan dated 4-1-16 recorded services for staff assistance "with all aspects of medication management." Review of Medication Administration Record (MAR) for June 2016 revealed the following	S3200		

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S3200	Continued From page 17 medications lacked documentation of administration: Creon 36,000 units (pancrelipase) 1 capsule on 6-23-16, 6-27-16, 6-28-16 at 5:00 pm and 6-29-16 at 9:00 am and 12:00 pm. Imodium 2 mg capsule (anti-diarrheal) 2 caps on 6-23-16, 6-28-16 and 6-29-16 at 5:00 pm. Levothyroxin 88 micrograms (hypothyroidism) on 6-5-16, 6-12-16, 6-21-16 at 7:00 am. Review of MAR for July 2016 revealed the following medication lacked documentation of administration: Imodium 2 mg cap (anti-diarrheal) 2 caps on 7-2-16 at 5:00 pm; Miralax Powder (laxative) 17 grams on 7-2-16 at 9:00 am; Cephalexin 500 mg (antibiotic) on 7-1-16 at 9:00 am and 8:00 pm; and 7-2-16 at 9:00 am. Interview on 7-7-16 at 3:30 pm with administrative staff A and administrative staff B confirmed the MARs lacked documentation of administration of medications on the above dates and times. - Record review for resident #708 revealed admission on 1-16-16 with diagnoses Hypertension, Diabetes Mellitus, Pacemaker, Alzheimer's Dementia, Atrial Fibrillation and Hearing Loss. The Functional Capacity Screen dated 4-5-16 recorded resident unable to perform management of medications/treatments. The Negotiated Service Agreement/Health Care Service Plan dated 4-1-16 recorded services for staff assistance "with all aspects of medication management."	S3200		

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S3200	Continued From page 18 Review of Medication Administration Record (MAR) for May 2016 revealed the following medication lacked documentation of administration: Lantus Insulin 10 units subcutaneously on 5-21-16 at 8:00 pm; Donepezil 10 mg (milligrams) (Dementia) on 5-16-16 at 8:00 am; Lasix 20 mg (diuretic) on 5-16-16 at 8:00 am; Tradjenta 5 mg (Diabetes) on 5-16-16 at 8:00 am; Eliquis 2.5 mg (blood thinner) on 5-16-16, 5-22-16 and 5-31 at 8:00 am; Vitamin C 500 mg (supplement) on 5-16-16, 5-22-16, 5-31-16 at 8:00 am; Bactroban ointment (topical) on 5-9-16, 5-16-16, 5-23-16, 5-28-16, 5-31-16 at 8:00 am. Interview on 7-7-16 at 3:30 pm with administrative staff A and administrative staff B confirmed the MARs lacked documentation of administration of medications on the above dates and times. For residents #702, 703, 704, 708, the administrator failed to ensure that all medications and biologicals are administered in accordance with professional standards of practice.	S3200		
S3247 SS=F	26-41-102 (c) Staff Qualifications RN available (c) A registered professional nurse shall be available to provide supervision to licensed practice nurses, pursuant to K.S.A. 65-1113 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(c)	S3247		

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S3247	Continued From page 19	S3247		

The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for all residents, the administrator failed to ensure a registered nurse was available to provide supervision to licensed practical nurses, pursuant to K.S.A. 65-1113 and amendments thereto.

Findings included:

- During entrance interview on 7-5-16 at 12:45 pm with administrative staff A and administrative staff B, stated licensed staff C was a Licensed Practical Nurse (LPN) and all current nurses on staff were also LPNs. Administrative staff B provided the name of a consulting RN who was available provide supervision to the LPNs but confirmed this RN lacked licensure in Kansas.

Review of personnel list completed by the administrator revealed licensed staff C with date of hire 2-4-16. Review of list of facility staff revealed 6 LPNs who are currently working at the facility. The list lacked a Registered Nurse (RN).

Interview on 7-7-16 with licensed staff D stated he/she had not been given the name of an RN to contact for questions or issues and did not realize his/her practice required RN supervision.

Per interview and written statement provided on 7-7-16 by administrative staff B, stated an RN (licensed staff G) was contacted "as needed for nursing questions until July 31, 2015 when his/her licensed lapsed." Provided a written statement from licensed staff G (an RN) confirming he/she would be available for facility staff effective immediately. Administrative staff B confirmed the facility LPNs had worked without RN supervision

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S3247	Continued From page 20 from 7-31-15 to 7-7-16. For all residents, the administrator failed to ensure a registered nurse was available to provide supervision to licensed practical nurses, pursuant to K.S.A. 65-1113 and amendments thereto. The administrator failed to ensure an RN was available to provide supervision to the facility LPNs from 7-31-15 to 7-7-16.	S3247		
S3260 SS=D	26-41-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and	S3260		

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S3260	Continued From page 21 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(3) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for 1 of 6 sampled residents, the administrator failed to ensure the resident record contained the admission agreement and any amendments. Finding included: - Record review for resident #705 revealed admission on 6-18-16 with diagnosis Hypertension. The record lacked the admission agreement. Interview on 7-6-16 at 2:50 pm with administrative staff A stated he/she was unable to locate the resident's admission file which included the admission agreement; confirmed the record lacked an admission agreement. For resident #705, the administrator failed to ensure the resident record contained the admission agreement and any amendments.	S3260		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive	S3298		

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S3298	Continued From page 22 value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 70 residents. The sample included 6 residents and 2 closed record reviews. Based on record review and interview for all residents, the administrator failed to ensure food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. Findings included: - Record review on 7-5-16 at 1:20 pm of Food Temperature Logs for June 2016 and July 2016 revealed the log lacked documentation of temperatures for the following dates/meals (note B=breakfast, L=lunch, D=dinner): 6-1-16 to 6-5-16 (all meals); 6-6-16 (D); 6-7-16 to	S3298		

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S3298	Continued From page 23 6-18-16 (all meals); 7-1-16 to 7-4-16 (all meals). Interview on 7-5-16 at 1:20 pm with Food Service Director confirmed the food temperature logs lacked documentation of temperatures on the above dates/meals with no other comment as to whether the temperatures were taken or not. Observations special care units on 7-6-16 and 7-7-16 around 12:30 pm and 5:30 pm respectively revealed staff serving residents from hot cart. No observation of staff taking food temperatures prior to serving. Interview on 7-6-16 at 4:50 pm with certified staff F confirmed there were no food temperature logs for the unit as they did not check food temperature prior to serving. Review of facility policy for Food Preparation stated: "2. Preparation - Food items are prepared with proper and established guidelines for the item...check temperatures prior to serving to ensure proper temperature." Interview on 7-5-16 at 4:00 pm with administrative staff B confirmed the dietary staff failed to follow the facility policy and further confirmed the policy lacked instructions for recording of food temperatures. For all residents, the administrator failed to ensure food shall be prepared using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature when staff failed to take food temperatures in the main kitchen on multiple dates and failed to have procedures for taking food temperatures on the special care unit before the food was served.	S3298		

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